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ABSTRACT

Developed by a 25-member committee representing health service institutions, educational institutions, manpower organizations, and professional groups, this publication contains guidelines for use in developing programs for physician's assistants. Suggestions are made for: (1) determining the role of the physician's assistant in relation to other health personnel, (2) defining the types and roles of physician's assistants, (3) recruiting and training the physician's assistant and associate, (4) career pathways for physician's assistants and other allied health workers, and (5) issues of licensure and/or certification. Several reactions to the guidelines are appended. (SB)

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# physicians' assistants

## guidelines suggested for their recruitment, training and utilization in Illinois

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PUBLISHED JOINTLY BY THE STATE INTER-AGENCY TASK FORCE ON HEALTH MANPOWER
AND THE INTERIM ORGANIZATION FOR CHICAGO AREA ALLIED HEALTH MANPOWER

# GUIDELINES

# FOR

# PHYSICIAN'S ASSISTANT PROGRAMS

# IN ILLINOIS

recommended by

THE AD HOC COMMITTEE

jointly assembled by

THE ILLINOIS INTER-AGENCY TASK FORCE ON HEALTH MANPOWER

and

THE INTERIM ORGANIZATION
FOR CHICAGO AREA ALLIED HEALTH MANPOWER

OCTOBER 1971

U.S. DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
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TO: Health Manpower Leaders in Illinois

FROM: Illinois Interagency Task Force on Health Manpower
and
Interim Organization for Chicago Area Allied Health Manpower

This document represents several months of deliberation by an Ad Hoc Committee appointed by the Illinois Interagency Task Force on Health Manpower and the Interim Organization for Chicago Area Allied Health Manpower for consideration of what directions Physician's Assistant programs should take in Illinois.

For anyone contemplating the use or training of Physician's Assistants in Illinois, we believe this discussion will provide a fuller view of both the possibilities and the pitfalls present in this emerging occupation.

At the present moment, as indicated in this document, the term "Physician's Assistant" means many things to many people. And, given the present differing patterns of training and utilization, we don't anticipate a complete clarification of roles and the universal acceptance of this new category of health worker for several years at the minimum. Under these circumstances, therefore, the work of the Ad Hoc committee looks more important today than it did nine months ago.

This is not a set of guidelines to instant or even eventual full implementation of a Physician's Assistant program. It is a thorough discussion, however, by knowledgeable leaders of a potentially usable tool for dealing with the multi-faceted demand in the health care system in Illinois for Physician's Assistant specialists and generalists.

Physician's Assistant-Associate workers are needed and will be utilized, although not universally in all health care components. In many situations they will meet with rigid opposition for a variety of reasons, some laudable, others deplorable, considering present unmet health care needs.

If we were to have only one effect...to dispel the prevalent notion among most laymen, and too many persons in the health field, that the role of the Physician's Assistant is fully understood and accepted, then our effort will have been worthwhile.

The twenty-five individuals who participated in the dialogue (see page xxxii) which produced this report represented a variety of interests and concerns with respect to the training and/or utilization of Physician's Assistants. Their participation does not imply endorsement of the paper as a whole, and in fact there are a number of areas of divergent opinion, some of them noted in the text.

However, all of them shared a concern for the total subject, its immediacy and the need for a thoughtful approach to implementing any program in Illinois.

Circulation of the original "posture paper", now comprising the first part of the document, resulted in a number of interesting direct and tangential reactions which are reproduced in an Appendix. These range from the very concrete and objective set of guidelines from the Illinois Hospital Association for assisting their members in grappling with what can be a complex medical - legal problem to some highly abstract and subjective personal opinions which constitute, in our judgment, an image of a Physician's Assistant who never was and never will be.

We have included these materials because they represent either an important consideration affecting the eventual use of Physician's Assistants, something to be incorporated in the training cycle or conceptual framework, or a widely-held point of view, rational or irrational, of which trainers or users of Physician's Assistants should be aware.

In reading this document it is important to remember that we are still in an emergent and experimental situation. We will fulfill our multiple expectations only by keeping in mind that not everyone is interested in the Physician's Assistant for the same reasons.

The Ad Hoc committee itself had such diversity of aspiration. Its members included persons affiliated with:

Health Service Institutions, looking to the PA as a means of relieving staff shortages and implementing new patterns of care.

Educational Institutions, committed to developing viable training programs to meet health care needs.

Manpower Organizations, motivated by the opportunity to provide jobs with genuine career advancement for new health care workers, and

Professional Groups, concerned with ways in which the PA will affect the roles and responsibilities of other health workers.

Their dialogue is only a beginning. Many remaining issues and problems will only be resolved as actual programs emerge and Physician's Assistants are utilized in our changing health care system.

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# GUIDELINES FOR PHYSICIAN'S ASSISTANT PROGRAMS IN ILLINOIS

## I

## STATEMENT OF PURPOSE

In developing these Guidelines for Physician's Assistant our first and major concern is to encourage programs designed to meet the health care needs of the people of Illinois.

We are also aware that the growing national and local interest in the training and utilization of Physician's Assistants makes it imperative for the State of Illinois to develop a coherent set of public policies with respect to this new source of health manpower. Since educational institutions, health care agencies and other governmental jurisdictions may also become directly involved in the training and/or utilization of these workers, it is essential that all such efforts be planned within the framework of a consistent set of agreed upon goals.

In the absence of such a commitment to collaboration, we run the risk of proliferating a disarray of poorly conceived programs which may become a liability both to the public and to the persons who seek career opportunities as Physician's Assistants.

It is with this concern for the public interest and for the maximum utilization of our human, educational and fiscal resources in Illinois that we have addressed

ourselves to the task of developing these proposed guidelines.

It was our purpose to affect as broad a consensus as possible among concerned agencies and organizations with respect to the major policy issues involved. We then propose to submit these recommendations to appropriate public and private agencies who are presently planning such programs or will have a direct interest in their implementation.

## II

## RATIONALE FOR THE PHYSICIAN'S ASSISTANT

We support the introduction of Physician's Assistant Programs in Illinois and encourage educators, health care practioners and health care institutions to begin collaborative planning and development of such programs.

In taking this position we wish to make it clear that we are unequivocally opposed to any programs which compromise the quality of medical care or set up a second class of health care services for poor people. Our support for Physician's Assistant Programs is based upon our conviction that the effective utilization of this new manpower will significantly improve the quality and accessibility of health care services available to the entire community.

We wish to emphasize, however, that the introduction of new manpower into our existing health care system will not in itself resolve the multitude of problems

we confront in providing adequate health care for all the people in Illinois. It has been demonstrated in many settings that, by employing allied health workers, it is possible to increase the number of patients served as well as to make more effective use of resources and skills available within the present health care delivery system. Programs which merely infuse additional workers into the present health care system do not, however, address themselves to the urgent need for re-examining and reorganizing the existing system.

In our judgment the optimum utilization of health manpower can best be achieved by effecting basic substantive changes in our health care delivery system. Only within a health care system which:

1. reorganizes its community health care resources to provide direct access to health care services for all persons in the community;

2. makes more rational use of all the scarce skills of its professional manpower; and

3. utilizes the full human potential of its allied health workers

will the Physician's Assistant, or any other health worker, make his optimal contribution. In a rational system of manpower utilization scarce professional skills will not be wasted on tasks which can be performed competently by lesser trained individuals. At the same time, every effort will be made to develop the full potential and maximize the contribution of workers at all levels.

We are witnessing at this time, both in Illinois and in the nation as a whole, the acceleration of efforts to re-examine and reorganize our health care delivery

system. While a consensus has not yet been achieved concerning the characteristics and components of a reorganized system of care, we anticipate that the emergence of a new health care system will be accompanied by the establishment of new health care institutions in new settings. Within this framework the present shortage and maldistribution of health manpower, which already presents a national emergency, will be intensified, particularly in disadvantaged inner city neighborhoods and rural areas. We look to the utilization of Physician's Assistants in these new health care institutions and settings as one way to help relieve both the manpower shortage and the maldistribution of health care personnel.

With the expansion of training opportunities, particularly at the community college level, we will also open for the first time a large new arena of job opportunities for persons who up to now have been excluded from any but the most low pay and low skill occupations in the health care field.

In summary, then, we support the training and utilization of Physician's Assistants for these reasons:

1. To produce some of the new manpower needed to provide full health care services and thus to facilitate the changes now occuring in the organization of the health care delivery system; and

2. to open up career opportunities in the health care field to large numbers of new workers presently excluded or underutilized.

## III

## ROLE OF THE PHYSICIAN'S ASSISTANT VIS-A-VIS THE PHYSICIAN AND OTHER HEALTH WORKERS

To make maximum use of the new manpower resources represented by the Physician's Assistant we will need to re-examine the functions performed both by the physicians and other workers employed in the existing health occupations.

In our task force discussions some concern was expressed with respect to how the Physician's Assistant functions will relate to the tasks performed by other workers. We wish first to emphasize that the use of Physician's Assistants is intended to fill a present manpower and service gap and not to replace other members of the health care team. We have also concluded that such questions as to what constitutes an appropriate division of labor, the issue of who has legal liability, who is superior and who subordinate in the work situation, along with other administrative matters, cannot be neatly defined or resolved in a general guidelines document.

These are matters which are best dealt with in the specific institutional setting. Their solution will depend upon the variables present in each situation; such as, the nature of a particular service program, the administrative style of its supervisors, the size and unique competencies of its staff. As we begin to develop some experience with this new member of the health care team, it will no doubt be possible to draw some general conclusions based on concrete observations about what works most effectively.

In the interim, it is evident that significant changes are already taking place in our concept of the physician's role as a result of the nationwide interest developing in a comprehensive health maintenance and medical care system. In the development of such a comprehensive health care system, the following examples are offered as illustrations of the functions which it is anticipated may be performed by Physician's Assistants and other allied health workers:

A. Development of the Data Base

The first step in the management of the healthy person or the sick patient is the development of the data base. There is considerable evidence as a result of a broadening body of experience that most of the health data base can be acquired in the absence of the physician. Furthermore, if we can agree on the content of the data base, it is likely that there will be more uniformity in its accrual in the absence of the physician.

In addition to performing tasks involved in eliciting a patient's medical history, assistants can also undertake tasks involved in making physical examinations. The introduction of multiphasic screening programs has demonstrated that deviant physical characteristics can be recognized in the absence of the physician. While alternate methodologies are now in actual use, with a little imagination and foreseeable technical advance, the range of possibilities in this area is enormous.

In summary, the important fact is that the history and those components of the

physical examination necessary for development of the health data base and recognition of normalcy can be done efficiently by non-physicians.

B. Health Education

Another aspect of preventive medicine and health maintenance in which the physician's role should be re-examined is health education. In dealing with such problems as cigarette smoking, obesity, problems of sexual inadequacy, the control of alcoholism or drug addiction, we have substantial evidence that the doctor-patient relationship has not been as effective in changing behavior as the mass media, the national publicity given to special reports and the activities of self-help groups.

Nevertheless, the need persists for more effective dissemination of basic health information to both well and sick populations. Non-physicians, collaborating with an individual doctor in his office or hospital setting, can be delegated tasks of providing basic information, counseling and support to clients on a one-to-one basis. They can also be utilized in group, family and neighborhood outreach programs contributing to the prevention of illness through instruction.

C. Other Preventive Maintenance Functions

Physician's Assistants may also perform certain positive acts of intervention such as routine immunization, prophylactic dental care and therapeutic dietetics in those cases where the risk factors are already identified. Increasing use of such

Physician's Assistants can also be made in diagnosis or, in broader terms, in the evaluation and management of patients.

In the ideal system, the data base including history, physical examination and routine laboratory measurements will have already been performed, recorded and retrieved when the person becomes a patient. But, there is no reason why the Physician's Assistant or the office or hospital computer terminal cannot perform this task if it is not already completed.

D. Primary Medical Care System

These tasks may include the sorting of patients and their problems in accordance with predefined criteria which will vary with circumstances and the specialty of the physician. This can include a) actual symptomatic therapy of minor or chronic disability such as the common cold or recurrent osteoarthritic pain; b) the broadening of the data base before the patient sees the physician by such acts as securing a throat culture, ordering a blood count or urinalysis, x-ray or electrocardiogram; or c) the establishment of temporal priorities for care and the referral elsewhere for care when appropriate. Assistants may also be assigned responsibility for the ongoing management of certain clinical categories. Examples include well-baby care, normal prenatal care and midwifery.

Other types of assistants will carry out technical aspects of the diagnostic and therapeutic process. Many of these are now functioning, but their scope of

activities will be broadened. These include 1) ophtalmological assistants; 2) orthopedic assistants; 3) coronary care assistants; 4) persons assisting in the emergency treatment of trauma and disaster victims on the trauma site, in a trauma center or hospital; 5) group therapists for patients with chronic, but stable diseases such as arthritis, neurological disability, diabetes, etc.; and 6) non-categorical specialists such as nutritionists, clinical pharmacists and nurse practitioners who will have new and expanded responsibilities for delivering various components of medical care management services.

The physician's role will be modified by the availability of the new technological tools provided by computers, general systems theory and industrial engineering techniques. Computers, for example, will relieve the physician of the necessity to rely on memory and will provide useful information to assist him in his decision-making process. The methodologies of the industrial engineer can help guide the diagnostic process in many categories of illness.

These methodologies are available to any physician. By following the recommended pathways, he can carry out a major part of the program in his own office with supplementary assistance provided by a central resource for those patients requiring the more complex techniques.

A final dimension of change in medical care management is being opened up by the communications media, including telemetry. These techniques are particularly

helpful in serving patients in remote and rural areas, for whom medical care is not presently available. Through the use of local human assistants and such technological supports, remotely located physicians should be able to direct the management of all people and to arrange for the transportation of those for whom only the physician's attention will suffice.

## IV

## DEFINITIONS OF TYPES AND ROLES OF PHYSICIAN'S ASSISTANTS

We have examined the definitions set forth by the National Academy of Sciences of the various types of Physician's Assistants. * While these definitions are clear, well stated and gaining considerable national acceptance, it is believed that certain qualifications and additions to these definitions are in order.

### A. The Titles

We accept the terms Physician's Assistant and Physician's Associate somewhat reluctantly. It is true that many of these new workers will be used in settings where they will provide, along with others, direct assistance to a physician. However, in view of the tasks expected to be performed to an increasing extent by non-physicians in the emerging health care system, we have difficulty in justifying the terms Physician's Assistant and Physician's Associate for all of these workers. More appropriate titles might be Health Care Assistants and Health Care Associates,

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* See Appendix I for National Academy of Sciences' Definitions.

titles which describe more precisely the roles that large numbers of these workers will in fact be performing.

This is particularly the case with the Physician's Associate level. While we are aware that Physician's Assistants may to a large extent be employed by physicians and work directly under their immediate supervision, there is reason to assume that in the changing health care system, Associate level workers will begin to function in more autonomous professional roles. In the future Health Maintenance Organizations, for example, to which Governor Ogilvie in his recent health message has stated his commitment, it can be anticipated that Associate level workers will play a major role in health care management.

The categorization of workers as "Assistants" to a physician also creates unnecessary confusion and negative response among other health professionals and allied health workers, many of whom have provided varieties of "assistance" to the physician for many years.

The terms Physician's Assistant and Physician's Associate are also not congruent with the growing acceptance of the health care team concept, a concept which sees all members of the team as partners, working together and assisting one another. Furthermore, while health care teams in many settings will be under

the continuing full-time supervision of a physician, others in our changing health care system may be required to function with part-time physicians or consultant physicians available as needed by the team. It would seem inappropriate, therefore, to designate all of these new members of the health care team as "Physician's Assistants." For the same reasons, we do not totally accept the A, B and C classification categories used by the National Academy of Sciences. These designations do not add to our understanding of the various roles to be performed and imply a hierarchical order which adds to the confusion.

If we accept the National Academy of Sciences' use of the terms Physician's Assistant and Physician's Associate, therefore, we do so for two pragmatic reasons: 1) there is considerable advantage to going along with a national trend, in that persons trained under titles used exclusively in Illinois may experience difficulty in gaining acceptance elsewhere; and 2) the titles Physician's Assistant and Physician's Associate apparently serve as an attractive recruitment device to persons considering a career in this occupation. We would recommend, however, that the National Academy of Sciences and other concerned organizations consider the advisability in moving toward occupational titles which more accurately describe the total range of functions to be performed by these new members of the health care team.

B. Proposed Illinois Definitions*

## THE PHYSICIAN'S ASSOCIATE

The Physician's Associate is capable of approaching the patient, collecting historical and physical data, organizing these data, and presenting them in such a way that the physician can visualize the medical problem and determine appropriate diagnostic or therapeutic steps. He is also capable of performing certain diagnostic and therapeutic procedures and co-ordinating the roles of other, more technical, assistants. While he functions under the general supervision and responsibility of the physician, he might, under special circumstances and under defined rules, perform without the immediate surveillance of the physician. He is thus distinguished by his ability to integrate and interpret findings on the basis of general medical knowledge and to exercise a degree of independent judgment.

## THE BASIC PHYSICIAN'S ASSISTANT

The Basic Physician's Assistant employed by an individual physician, a group of physicians, or in a medical care setting supervised by physicians will function under the direct and continuing surveillance of the physician. His duties will be explicitly stated by the physician and the tasks delegated to him will be those which, in the judgment of the physician, can be competently performed by the Assistant. On the whole, the range of tasks will be diverse in nature and will reflect the scope and characteristics of the physician's practice and the medical care services provided in a specific setting. Basic Assistants employed in health maintenance settings may also function under the direct and continuing surveillance of those staff persons who are responsible for the administration and supervision of the health care services program, some of whom may be non-physicians.

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* These definitions are to a large extent based on the National Academy of Sciences' document on this subject. They are, however, revised to include certain modifications and additions proposed for use in Illinois.

## THE SPECIALIST PHYSICIAN'S ASSISTANT

The Specialist Physician's Assistant is a worker trained to perform in one clinical specialty or, more commonly, in certain procedures within such a specialty. In his area of specialty, he has a degree of skill beyond that normally possessed by a Physician's Associate and perhaps beyond that normally possessed by physicians who are not engaged in the specialty. Because his knowledge and skill are limited to a particular specialty, he is less qualified for independent action in areas which do not pertain to that specialty. An example of this type of assistant might be one who is highly skilled in the physician's functions associated with a renal dialysis unit and who is capable of performing these functions as required. In all cases, the duties of the Specialist Physician's Assistant are implicit in his special set of skills; i.e., his training in a particular specialty circumscribes the range of his tasks. Within his own special skill area, however, he will frequently function with a considerable degree of responsibility and independence.

## V

## RECRUITMENT AND TRAINING OF THE PHYSICIAN'S ASSISTANT AND ASSOCIATE

### A. Training Content

The content of any training program should be based upon at least three major factors: first, the nature of the employment setting, whether private practitioner, group practitioners, Neighborhood Health Centers, hospitals, clinics, etc.; second, the level of competency expected, whether technician, assistant or associate; and third, the level and extent of responsibility, ranging from total supervision to substantial independence of action.

For programs at both Assistant and Associate levels we encourage the schools to consider introducing a core curriculum, containing those basic courses which are generally applicable to the preparation of all allied health workers. It is highly desirable that the schools also develop some agreement as to the components of such a core curriculum, so that at least in Illinois the training completed in one school will be acceptable and accreditable in other sectors of the State.

This core will need to be supplemented, however, by special course work designed to prepare students to perform the specific work roles identified by potential employers collaborating with the school.

We recommend that no training programs be approved until reasonable efforts have been made by the training institution and potential employers of graduates to collaborate in the construction of such job descriptions which specify the nature and extent of the knowledge, competencies and skills required for actual job performance in the different settings and for the various categories of employment for which the training is being designed. Such occupational, job or task analysis will determine the amount, kind and time of the specialized training component and assure maximum "fit" between training and job performance. It is essential that the competency level be identified to the greatest extent possible before the educational level.

A large majority of the Committee also recommends that as much as possible of the

Physician's Assistant curriculum at the junior-community college level be devoted to occupationally relevant training, leaving certain selected liberal arts offerings to be acquired at later, different, or higher levels of education involving qualifications for conventional credentials.

B. The Education Ladder

A variety of educational settings are necessary to train Physician's Assistants and Physician's Associates, ranging from the community college to the medical school. The community colleges are urged to establish two-year Associate of Applied Science programs for both the Basic and Specialist Physician's Assistants. The four-year colleges and medical schools are urged to establish four-year programs for the training of Physician's Associates. In both cases, we strongly recommend that allied health workers with prior training and experience, including returning medical corpsmen, be permitted to enter these educational programs on an advanced placement basis, depending upon their individual competencies, through equivalency testing or other means.

C. Assurances to the Trainee

Educational institutions should be required to develop and establish experimental training designs in affiliation with quality clinical training institutions and are urged to build into their curricula four assurances on behalf of students: first, that jobs do in fact exist for the graduates of the program being planned; second,

that the curriculum result in bargainable and employable knowledge, competencies and skills; third, that the credential or degree awarded provide negotiable credit and advanced standing toward higher or different levels of work and responsibility within the categories of Physician's Assistant and other health professions and skills; and fourth, that trainees have the opportunity to be closely associated in training settings with physicians and other allied health workers.

### D. Recruitment Priorities

Manpower needed for the medical-health field, including Physician's Assistants, must be sought from all possible sources. While members of existing allied health professions should have the option to enter this new profession, recruitment efforts should obviously be directed to expanding the available manpower pool by attracting new or inactive health workers into these programs. Equity and necessity also demand distinct efforts to recruit persons from the educationally and economically disadvantaged groups in the population. The junior-community college provides a major avenue of opportunity for such individuals for specific entry to the health fields through the occupation of Physician's Assistant.

## VI

## CAREER PATHWAYS FOR PHYSICIAN'S ASSISTANTS AND OTHER ALLIED HEALTH WORKERS

### A. A Comprehensive View

In introducing the Physician's Assistant and Physician's Associate to the health care

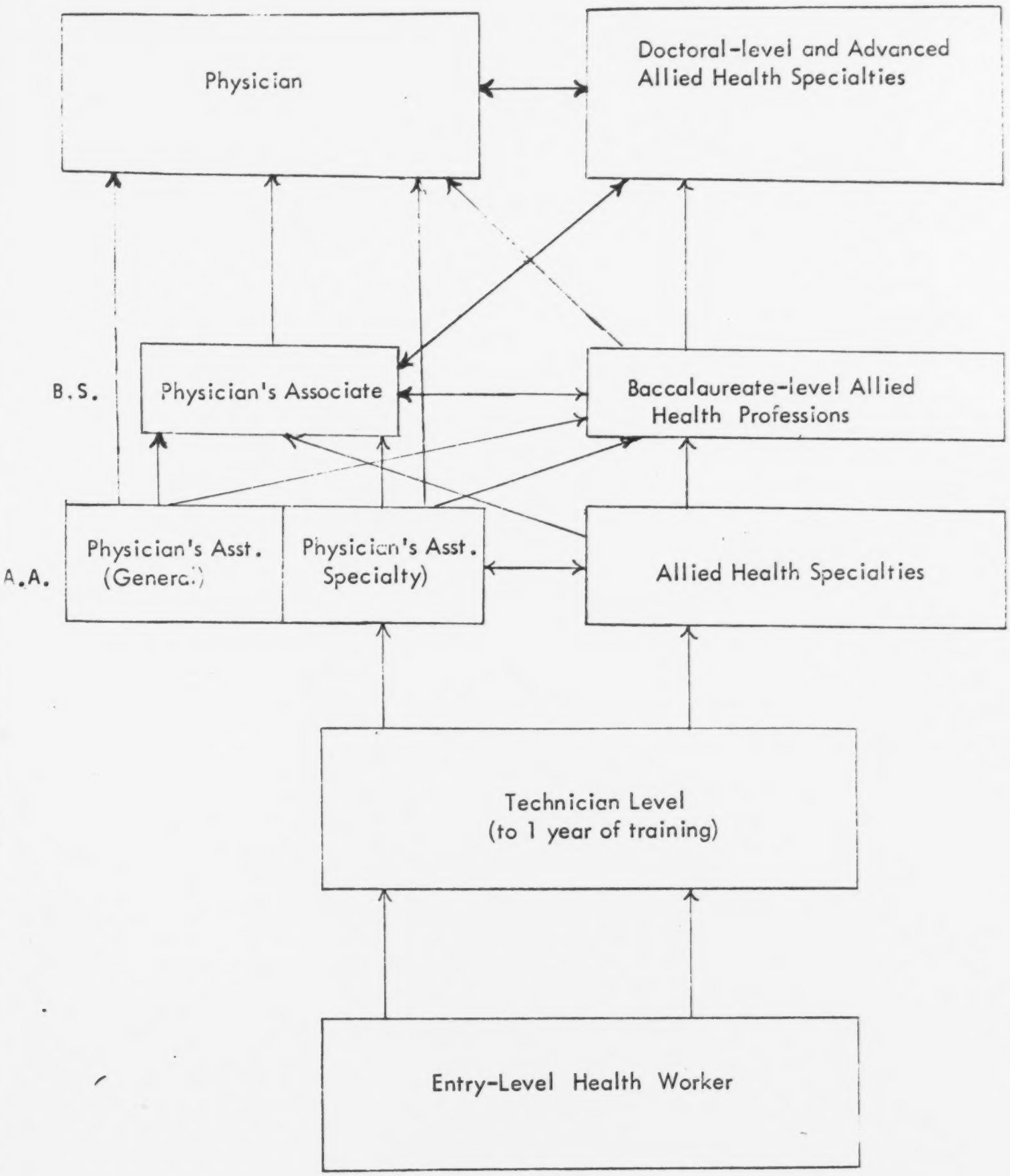
system in Illinois, it is essential to design both training programs and personnel structures in such a way as to broaden the career options and thus provide maximum occupational mobility for these new health care workers.

In undertaking this effort to integrate the planning of education ladders with job mobility ladders, however, we must be equally concerned with the needs of all those allied health workers who now find themselves with dead end training in dead end jobs and who seek opportunities for upward mobility.

We therefore propose that the problem be approached comprehensively, that we begin to design and implement a career mobility system which offers all allied health workers the opportunity to build incrementally on prior training and experience and to advance into more responsible and higher paying positions.

B. A Career Opportunity System

In the following diagram, we have illustrated how such a career opportunity system would operate to provide vertical and horizontal mobility to Physician's Assistants as well as to other allied health workers. From the unskilled man-power pool, workers recruited for the health occupations enter into training programs which prepare them to function in entry level positions. Completion of these training programs, including the G.E.D. preparation, ranging from several weeks to one year result in the award of a certificate by the high school




Model Career Pathways for Health Field with Physician's Assistant and Physician's Associate

or community college collaborating with the employer.

Workers are allowed release time to proceed from this level to complete work toward the Associate of Arts or Applied Science Degree, having been granted full credit through equivalency testing or articulation agreements for their prior training and experience.

Since the Physician's Assistant training program is seen as a two year course of study, students may include both new entries into the health care field as well as members of the existing allied health work force, including, for example, returning Medical Corpsmen. The Physician's Assistant Program itself provides two options: the Basic Physician's Assistant Course and the Specialist Physician's Assistant Course.

Persons who have completed a two year allied health program or its equivalent in prior training or experience should be able to proceed toward the Bachelor of Arts in the same fashion, adding whatever course work is required to perform competently at this work level. Persons entering Baccalaureate programs may choose from a number of career pathways to become Physician's Associates, Nurses, or other kinds of specialized health workers.

The same principle applies and the same opportunities are available for further training at the Doctoral level. In all cases, we anticipate that many workers will

be attracted to different and/or more challenging areas as they gain more exposure to the spectrum of opportunity available.

C. Preconditions for Success

The successful implementation of these career ladders and lattices is contingent upon close collaboration between employers and all sectors of the Illinois educational system, including the high schools, community colleges, four year colleges, universities and medical schools. Such collaboration is required to create the following preconditions for effective implementation:

1. That employers will negotiate with local educational institutions to integrate their in-service training programs with established educational curricula so that on-the-job training is fully accredited as part of the educational institution's certificate or degree program;

2. that local educational institutions and employers will make practical arrangements for employees to acquire the supplementary training not available through in-service programs, thus enabling workers to complete the academic work required for the award of a certificate or degree;

3. that educational institutions will fully accept and implement the practice of equivalency testing so that workers may proceed into advanced training programs without starting all over again; and

4. that educational institutions, employers and professional groups will recognize the common components of training implicit in the preparation of all allied health workers and proceed to design health core curricula at all educational levels.

In our judgment, implementation of this career system will also provide for greater efficiency in the management of the work force, particularly in situations where

(1) there is a regional surplus developed in a particular area; (2) there develops a need for new kinds of workers as a result of technological or delivery system change; and (3) when, as a result of such changes, certain professions or skills become obsolete.

## VII

## RECOMMENDATIONS RELATED TO ISSUES OF LICENSURE AND/OR CERTIFICATION

We are opposed to any measures at this time which may require mandatory licensure or certification of Physician's Assistants by State or local authorities for the following reasons.

1. It is in the public interest to stimulate and support broadly innovative approaches to the development and utilization of new manpower. Legal restrictions at this time may seriously inhibit the process of experimentation and testing out which are necessary if we are to explore new roles, functions and patterns of manpower utilization in the health care field.

2. Major national health organizations at this time are advocating a moratorium on moves to extend licensing or certification to new sectors of health manpower. This reflects the concern of both professional and lay groups with:

    a. the excessive legalized fragmentation of the health care occupations;

    b. the limitations placed by these regulations on the occupational and geographic mobility of health care workers; and

    c. the general lack of public and consumer representation on licensing boards throughout the country.

3. Far more effective controls to maintain the quality of health care can be built into the institutions responsible for the training of Physician's Assistants and into those settings which utilize them as members of the health care team.

4. It is unnecessary in this State to provide statutory authority for the use of Physician's Assistants, since the Illinois Medical Practices Act already gives the physician considerable latitude in delegating tasks under his "responsible supervision."

# APPENDICES

Appendix I

# *New Members of the Physician's Health Team:*

# PHYSICIAN'S ASSISTANTS

Report of the Ad Hoc Panel
on New Members of the Physician's
Health Team
of the
Board on Medicine
of the
National Academy of Sciences

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NATIONAL ACADEMY OF SCIENCES
2101 CONSTITUTION AVENUE
WASHINGTON, D. C. 20418

BOARD ON MEDICINE

May 13, 1970

Dr. Philip Handler
President
National Academy of Sciences

Dear Dr. Handler:

I am enclosing a report on a study conducted by the Panel of the Board on Medicine entitled, "New Members of the Physician's Health Team: The Physician's Assistant". The Panel was under the Chairmanship of Dr. Eugene A. Stead, Jr. The Board had an opportunity to review the study as it was in progress and has unanimously approved the final report. It should be emphasized that this study, which is planned as one of a series, is focused sharply on only one aspect of the broad subject of paraprofessionals in health services, namely on the so-called physician's assistant.

There are several reasons why the Board believes that there is a need for a statement on this question at this particular point in time: first, it is essential that flexibility be preserved in the development of the various types of physician's assistants, yet already attempts are being made to embody fixed criteria into state licensure procedures; second, despite all the publicity given to the concept of the physician's assistant, it is essential that authoritative groups, speaking from a strong medical base, lend sanction to the development; and, third, considerable interest has been expressed by the Departments of Health, Education, and Welfare and Defense in the subject of new type careers in health care for returning veterans with experience as medical corpsmen. The Board believes that the present report represents an excellent definition of the overall problem and characterization of the broad alternatives.

Sincerely yours,

Walsh McDermott, M.D.
Chairman

Enclosure

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## GENERAL BACKGROUND

The Board on Medicine of the National Academy of Sciences is continually searching for "points of leverage" in the health field at which modest investments of energy and money can result in substantial improvements in the delivery of health care to the American people. Health care involves many professions and institutions, including several different types of delivery systems. One such system, and unquestionably the one most familiar to the public, is the system for the delivery of personal health services. These personal services are given largely by physicians, nurses, and various other personnel, but only the physician is equipped by education and training for certain critical roles.

In recent years and largely as a consequence of developments in biomedical research, the radius over which the physician can exert his influence has been steadily shortened. He can do far more things, but he does them for fewer people. Some means of compensating this situation must be found if the goal of satisfactory medical services for all is to be met.

The Board on Medicine believes that the development of better clinical support systems to help the physician deliver personal health care to deliver more units of personal health services per hour of his working day are now in the offing. In developing such systems, it is important to preserve sufficient flexibility to permit continued innovation and experimentation. One threat to such continued flexibility would be the premature incorporation into licensure laws of the job qualifications of various types of new health workers. One of the purposes of this report, which presumably will be one of a series, is to call attention to this danger. The principal focus of the report is on one of the possible new types of health workers, specifically on those that serve as immediate "extensions" of the physician.

It is anticipated that the new health personnel in general, and the systems they will man, will include various combinations of traditional personnel—physicians, nurses, dietitians, and others; new machines—computers, autoanalyzers, biomedical instrumentation; and new types of assistants, including those working at the physician-patient interface. Assistants of this last type*—the type discussed in the present report—differ from other health-related personnel in that they are selected by physicians, trained by physicians, and report administratively directly to physicians. They serve to extend the arms, legs, and brains of the physician. They interact at the physician-patient interface and are capable, under the direction of the physician, of performing functions now usually performed by physicians.

*Fixed titles for the different categories of assistants described in this report have not been established. There are indications that the Type A assistants described in this report will be called physicians' associates.

Another reason for examining this question at this time is that the armed services are returning to civilian life large numbers of men who have worked effectively in the military medical corps; the Departments of Defense and Health, Education, and Welfare are looking for guidance in determining effective ways to open up careers in the health field for these veterans. One way would appear to be the development of these new assistants. The Board believes that, along with expansion of the functions of other health professions, the use of these new assistants will permit development of new patterns of medical practice, and that the impact of new alignments of functions and newly trained people will be as immediate as that of new institutional forms and new machines. For these several reasons, therefore, the Board formed a panel to examine (1) the factors leading to development of these new assistants, and (2) the relationships between these assistants and the personnel who have traditionally helped the physician. The results of the study, which was reviewed by the full Board at several stages, are presented in this report.

## THE NEED FOR NEW PERSONNEL

The current output of medical schools, plus the output of new and expanded schools, will be insufficient to provide personal health services to those segments of society now being served, while extending services to those segments now receiving little or no care.

Even if sufficient expansion of physician output to meet the total need for services could be achieved, it is doubtful that this expansion would be a wise course, since certain tasks do not require the unique talents of the physician and may be effectively performed by personnel with less total training, at less cost to the consumer.

Personnel in the existing manpower categories (such as professional nurses and physical therapists) could assume many health-service functions with added training, but should not be considered as the sole or even primary pool supplying personnel to these new health professions. A new primary pathway into the new class of physician's assistantships would tend to extend the range of health careers and would enhance the potential for recruitment of male as well as female candidates.

## TYPES OF PHYSICIAN'S ASSISTANTS

In view of the great variety of functions of physicians' assistants, the variety of circumstances in which these functions might be performed, and the different sorts of skills and knowledge necessary to perform them, it is neces-

sary to describe several types of physician's assistants. These types are distinguished primarily by the nature of the service each is best equipped to render by virtue of the depth and breadth of their medical knowledge and experience. The Type A assistants are new to the American scene. Types B and C assistants have been present in one form or another for a number of years.

## CATEGORIES OF PHYSICIAN'S ASSISTANTS

### The Type A Assistant

The Type A assistant is capable of approaching the patient, collecting historical and physical data, organizing these data, and presenting them in such a way that the physician can visualize the medical problem and determine appropriate diagnostic or therapeutic steps. He is also capable of assisting the physician by performing diagnostic and therapeutic procedures and coordinating the roles of other, more technical, assistants. While he functions under the general supervision and responsibility of the physician, he might, under special circumstances and under defined rules, perform without the immediate surveillance of the physician. He is, thus, distinguished by his ability to integrate and interpret findings on the basis of general medical knowledge and to exercise a degree of independent judgment.

### The Type B Assistant

The Type B assistant while not equipped with general knowledge and skills relative to the whole range of medical care, possesses exceptional skill in one clinical specialty or, more commonly, in certain procedures within such a specialty. In his area of specialty, he has a degree of skill beyond that normally possessed by a Type A assistant and perhaps beyond that normally possessed by physicians who are not engaged in the specialty. Because his knowledge and skill are limited to a particular specialty, he is less qualified for independent action. An example of this type of assistant might be one who is highly skilled in the physician's functions associated with a renal dialysis unit and who is capable of performing these functions as required.

### The Type C Assistant

The Type C assistant is capable of performing a variety of tasks over the whole range of medical care under the supervision of a physician, although he does not possess the level of medical knowledge necessary to integrate and interpret findings. He is similar to a Type A assistant in the number of areas in which he can perform but he cannot exercise the degree of independent

synthes s and judgment of which Type A is capable. This type of assistant would l e to medicine what the practical nurse is to nursing.

Presumably these new health careers would be open to members of either sex. Although practical nursing has in the past been a predominantly female occupation, some medical corpsmen, as they re-enter civilian life and seek careers in the health field, are taking the licensing exam and becoming practical nurses. There is no basis for preference for either sex relative to any of the assistant types described here.

As far as can be foreseen into the future, these assistants should perform as members of a health team under the general supervision and authority of a physician or group of physicians. The provision that they should perform in a dependent relationship with physicians in fact expands the range of functions that are or may come to be within their individual spheres of competence. Of the various independent practitioners in the health field, only the physician is authorized to perform independently over the full range of medical care. The more narrowly defined spheres of activity of other practitioners are likely to influence strongly, if not firmly dictate, the limit of their functions and development – if for no other reason than that they bear so heavily on the nature of the problems that will be presented to them. On the other hand, assisting with the variety of problems that confront physicians over time provides opportunities for continuous learning and encourages the development of new skills that would justify "rising ceilings" on the activities and careers of exceptionally able assistants.

The functions performed by such assistants should be within the scope of medical competence of the physicians under whom they work. For example, it would be inappropriate for a surgeon's assistant to perform a preoperative cardiac evaluation unless the surgeon is competent to review his work critically.

Some assistants may wish to become independent, and they may do so by obtaining an M.D. degree. On the basis of performance and equivalency exams they may demonstrate that they have mastered many of the functions and concepts normally taught medical students in their clinical years. Type A assistants should be able to go through medical school in less than the usual four academic years.

## GENERAL RECOMMENDATIONS RELATIVE TO EDUCATION AND TRAINING

### The Type A Assistant

For proper performance of the functions outlined for Type A assistants, the student must be able to use written and spoken language in effective communication with patients, physicians, and others. He must also possess

quantification skills to ensure proper calculation and interpretation of tests. He must also meet high ethical and moral standards. Because of the nature of the activities of Type A assistants, large investment of time by physicians is required for their training. Obviously, it would be wasteful to invest this valuable commodity in candidates who do not demonstrate ability to learn rapidly and who do not have exceptional enthusiasm for careers utilizing this knowledge and training. Every effort should be made to ensure that candidates accepted for training possess these abilities and characteristics.

The essential educational requirement for Type A assistants is the equivalent of two years of professional-level training in classroom and clinical work. Many candidates for Type A programs are likely to have completed the first two years of college. It should be emphasized, however, that a college background is not considered necessary for entry into a Type A training program or for the effective performance of the functions of a Type A assistant. The level of general education represented by a high school diploma should be adequate pre-professional education for a Type A, as well as Type B or C, assistant. The Type A assistant will work closely with physicians and other health professionals, most of whom will have a degree of some kind. For this reason, the assistant may feel more comfortable if he has a degree. Provision should be made, where possible, for those completing a Type A program to earn baccalaureate degrees if they so choose, either by applying their professional training toward completion of their previous college work or by completing the pre-professional college courses at a later time.

The critical requirement for admission to a Type A training program should be the candidate's demonstration that he possesses the abilities and characteristics called for above. The following illustrative examples may serve the purpose of establishing the necessary qualifications for admission to a program and are provided as guides:

1. For Degree-Granting Programs: A candidate may be selected for the professional portion of the training following successful completion of the first two years of course work required by an affiliated college or university as a part of qualification for a baccalaureate degree.

2. For Non-Degree (Certificate) Programs:

a. A candidate may be selected if he has a high school diploma or its equivalent and can furnish appropriate assurances of his character and commitment. Experience has demonstrated that among the most reliable indications that a candidate possesses the necessary intangible characteristics is a showing that he has background experience in health-related work, including education and experience in direct patient care, and statements of evaluation from physicians or others competent to evaluate the qualifications cited above.

b. A candidate may be selected upon a showing that he has a speci-

fied number of years experience as a Type B or C assistant, and evaluation statements from those responsible for his work.

The curriculum of a program training Type A assistants should include adequate instruction in the basic sciences underlying medical practice and sufficient exposure to clinical medicine to ensure understanding of patients, their ailments, and the diagnostic and therapeutic responses to those ailments. Thus, students must be given adequate exposure to physician instructors and to clinical training essentially the same as that given medical students. The Type A assistant will generally have four types of training: 1) basic general education; 2) basic scientific education; 3) general clinical training; 4) specialized clinical training in some aspect or aspects of medical practice. The first two types of training may be available at a variety of institutions, including junior and four-year colleges. Because of the amount of physician time necessary for the third and fourth types of training, however, it is unlikely that it will be economically feasible to provide it except in hospitals associated with medical schools and other institutions participating in the training of physicians.

Persons entering a program who have already acquired clinical knowledge should be given appropriate credit.

### The Type B Assistant

As for Type A assistants, the training of Type B assistants will require considerable participation by physicians. A significant portion of this training should be by physicians specializing in the area of the assistant's concentration because the Type B assistant will have a specialized skill in excess of that generally possessed by the ordinary physician. Because of the different nature of their activity, requiring less independence, the general education and clinical backgrounds of Type B assistants, of course, need not be as extensive as is suggested for Type A above.

Because of the specialized nature of the work and the narrow range of activity of a Type B assistant, the length of training required will tend to be more variable than for a Type A assistant.

### The Type C Assistant

Type C assistants, because they are non-specialized personnel, require less general education, basic scientific education, clinical training, and special-skill training than is necessary for Type A or Type B assistants. A larger portion of their training might be given outside a medical center, and much of their clinical training could be given on the job. The training programs for practical nurses usually provide the type of preparation necessary for performance of the duties of Type C assistants. Recognizing that Type C assistants may wish to become Type A or Type B, educational programs for Type

A and B assistants should give credit for appropriate educational and work experience acquired in Type C training. This and other provision for upward mobility is of great importance and should be built into the system.

## ACCREDITATION

Accreditation of programs should be in the hands of an accrediting agency. In medical education, this task has traditionally been performed under the auspices of the American Medical Association and the American Association of Medical Colleges, and it would be appropriate for these two organizations to establish the basis for review and approval of programs for the training of assistants.

In establishing criteria for entry into and mobility between groups of assistants, consideration should be given to proven competence as well as academic credentials. The accrediting agency should be aware of the fact that it is possible to establish the clinical and specialized skills of all three types of assistants starting with the basic background of a high school education. Recognizing that a non-degree (certificate) graduate may wish to achieve a baccalaureate degree later, it is urged that colleges consider a reversal of the usual sequence, permitting the professional courses to apply toward the degree, if the required pre-professional courses are completed later. The panel emphasizes that the success of this new concept in development of health personnel will depend in large measure on the flexibility of the approach of the accrediting agency.

## LEGAL AUTHORIZATION

The need for development of professional quality control through an accreditation mechanism is accompanied by the need to provide legal authorization for the use of these new types of assistants. Such authorization must derive from the individual states, which have traditionally provided the legal framework under which health care is delivered.

It should be emphasized that these types of assistants are unique in the medical field, and the extent of their potential contribution has not yet been determined. Because of its desire to preserve the flexibility necessary for the optimal use and full development of the individual assistant's capabilities, the panel feels that legal authorization should not be effected through licensure. A type of authorization built around a system of registration could be developed, which would permit qualified physicians to employ assistants if such assistants have completed an approved program or have otherwise established their qualifications to perform the duties proposed for them. The basic objective should be to provide guarantees of the qualifications of personnel without imposing the rigid definitions characteristic of licensing legislation.

## FUTURE IMPACT

Rapid strides have been made in recent years in expanding the scientific and technological knowledge that underlies medical care. Before the full potential of these advances can be realized, however, some resolution of the problems of physician shortage and maldistribution of medical care must be found. Discussions regarding the future of medical practice eventually lead to the conclusion that there must be major changes in the organization of health care delivery. Most such discussions lead to the conclusion that medical care must be organized into modes of service in which functions are coordinated and services rendered in such a way as to promote efficiency, convenience, continuity, and economy. Critical to the necessary reorganization is the utilization of different types of health care personnel.

Any mode of service developed must be capable of providing medical care to the many rural areas and depressed urban areas that are unable to attract and hold physicians. Technical interfaces, such as image transmission, might be developed to expand the physician's range of control and permit him to supervise an assistant physically separated from him. Skilled assistants will be needed to gather physical data, communicate it to the physician effectively, and administer the treatment prescribed by the distant physician. In addition, there is currently some speculation as to whether persons other than physicians might be able to act with some degree of independence in handling the more routine health problems in medically deprived areas. The development of assistants, such as those described herein, would contribute to the needed manpower pool and would provide an opportunity for experimentation with various combinations of personnel and technological advances.

## CONCLUSION

There has been much discussion of health manpower needs and of roles for new types of personnel, such as physician's assistants. There is a need for objective data, including measurements of the effect of such assistants on the quality and quantity of medical care delivered in various settings. This task cannot be accomplished unless health personnel are trained and placed in practice settings in sufficient quantity to allow reliable observations to be made.

Although there are still unanswered questions and unresolved problems, the existing and still-growing shortage of physicians places programs for training physician's assistants among the top priorities for the health professions. The Board on Medicine endorses the concept of expansion of physician services by the use of physician's assistants, endorses and supports continued exploration of the effects of such assistants in a variety of clinical settings, and urges the cooperation of the Association of American Medical



Colleges, the American Medical Association, and government in the establishment and review of educational standards for training programs, the resolution of legal difficulties, and the establishment of uniform systems for testing and certification of such assistants.

## APPENDIX II

ILLINOIS REGIONAL MEDICAL PROGRAM

Motion adopted by the Regional Advisory Group on March 22, 1971:

WHEREAS there is a need for greatly increasing the numbers and types of quality health personnel, including the need to utilize the returning armed forces personnel, and

WHEREAS many responsible educational institutions and agencies have undertaken the tasks of educating these new personnel without central coordination of these activities, and

WHEREAS premature introduction of licensure and certification may impede experimentation and development of new types of personnel,

THEREFORE BE IT RESOLVED THAT THE ILLINOIS REGIONAL MEDICAL PROGRAM

1. Supports the call for a moratorium on licensure and certification of health personnel until a concensus can be reached as to the responsibilities, functions, and relationships of such personnel, and

2. Supports and encourages the activities of the Illinois Interagency Task Force on Health Manpower in its efforts to resolve these issues and wishes to be kept informed of the progress of the task force.

ILLINOIS INTERAGENCY TASK FORCE ON HEALTH MANPOWER

March 31, 1971

FROM: Illinois Interagency Task Force on Health Manpower
Don C. Frey, Chairman

TO: Members of the Illinois Legislature

The Illinois Interagency Task Force on Health Manpower is a voluntary group co-sponsored by Comprehensive Health Planning, Inc. of Metropolitan Chicago, Health Careers Council of Illinois, Health Education Commission of the Illinois Board of Higher Education, Illinois Regional Medical Program and the State of Illinois Office of Comprehensive Health Planning. Its membership also includes representation from various professional organizations and other agencies concerned with health manpower in the State. The Interagency group hopes to serve a coordinating role in health manpower activities and believes that by merging the activities of these various groups it will minimize duplication of effort, yet have maximum impact in the health manpower field. A membership list is attached.

At its last meeting the Task Force voted unanimously in support of a moratorium on licensure of new health occupations. In essense, we agree with the recent positions of the American Medical Association, the American Hospital Association, and the Congress, who, in viewing the confusing status of health fields licensure, recommended a moratorium on new legislation until an effective assessment of the entire licensure question can be developed. The time limit on the moratorium should extend at least through the current legislative session. Moreover, because there are no physician's assistant programs currently in Illinois, an ad hoc committee has been formed and is drawing up guidelines in order to provide substantive guidance to groups developing such programs.

Finally, some of the issues related to physician's assistants that need collaborative decision before legislative action is taken are as follows: there must be agreement on the requirement for task analysis, definition of roles, educational experience, alternate pathways, states of dependency and independency, licensure and certification, and the question as to whether these physician surrogates are being developed for the purpose of perpetuating the existing relationship of physician to patient population or as needed personnel for service in the changing health delivery system.

We hope this information will be of use to you. Please feel free to call upon the expertise represented by the Task Force, if we can be of assistance to you.

For further information contact:

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Task Force Secretary
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APPENDIX III

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Northwestern University Medical School

**David M. Kinzer,** executive vice president

June 4, 1971

Myrna B. Kassel, PhD
201 North Wells Street, Room 1700
Chicago, Illinois 60606

Dear Myrna

re: Guidelines for Physicians Assistant
Programs in Illinois

The adhoc committee's report is good reading and good quidance. I shall eagerly look forward to its consideration at the next meeting of the Interagency Task Force, June 15. (Incidentally, this is my first and only notification of the upcoming meeting.)

A few comments:

I would suggest inclusion of the IHA Manpower Resolution (1970) in support of the moratorium. It predates the AHA and AMA statements. Besides, it is Illinoisian and originates in the IHA Conference Group on Education.

I would appreciate a clearly stated caveat against training physicians assistants to become "doctors of the poor" or "country doctors" for rural Illinois. Much of the rational for PA prograns supports these inferences.

Finally, I would suggest broadening the generic meaning of "physicians assistant" by recognizing PA roles for others, especially registered and licensed practical nurses, and for registered pharmacists. I will let you worry about stating when the role is "associate"or "assistant".

Sincerely

David W. Stickney
Associate Director

DWS:ngr

Memorandum

140 NORTH LAKE SHORE DRIVE • CHICAGO, ILLINOIS 60611 • 312/664-9500

July 8, 1971

TO : Administrators of Member Hospitals

SUBJECT: PHYSICIANS' ASSISTANTS

The attached document is prepared for guidance of Illinois hospitals, their administrations and medical staffs. It applies to any physician's assistant -- regardless of his title -- while working in the hospital fulltime or part-time under a physician's supervision. It applies whether the assistant is paid by the physician or the hospital and whether or not he has graduated from an established educational program for physicians' assistants.

The recommendations in the document are based upon the thesis developed over the past 15 months by IHA's Conference Group on Education, chaired by Joseph P. Greer of Children's Memorial Hospital, Chicago. Consideration of the emerging physicians' assistants category in hospitals has been a part of the conference group's broad study of health manpower, education and licensure, and of the group's plea for the licensure moratorium endorsed by the IHA membership at the 1970 Annual Meeting.

David W. Stickney
Associate Director

7/8/71:bjs

ILLINOIS HOSPITAL ASSOCIATION

Document

840 NORTH LAKE SHORE DRIVE • CHICAGO, ILLINOIS 60611 • 312/664-9500

# PHYSICIANS' ASSISTANTS IN ILLINOIS HOSPITALS

The Illinois Hospital Association and its Conference Group on Education believe that physicians' assistants can have important roles in hospitals. They can expand a hospital's capacity to deliver patient care and, to quote a statement of the National Academy of Science, "they serve to extend the arms, legs and brains of the physician."

There is no Illinois statute dealing specifically with "physicians' assistants," but IHA believes they are legal like dozens of other job categories as long as the hospitals in which they work are deliberately careful to safeguard patients. Such care is the subject of this IHA statement. The Illinois law which IHA has reviewed includes the State Supreme Court decision in Darling vs. Charleston Community Memorial Hospital (1965), the Medical Practice Act and the other health occupation licensure statutes, and the Illinois Hospital Licensing Act and Requirements. IHA also believes that physicians' assistants may be used within the standards of the Joint Commission on Accreditation of Hospitals effective July 1, 1971 (see Medical Staff, Standard VII and its Interpretation). Finally, if the hospital acts responsibly, there is no reason to expect any effect on the hospital's liability insurance.

Within this context, medical corpsmen being discharged from the armed services and the graduates of the nation's new physicians' assistants programs offer all hospitals an important new source of trained allied health manpower which should be utilized. Especially valuable are corpsmen who have completed one of the collegiate or university medical school physicians' assistants programs. (Hospitals are urged to utilize the placement service of the Health Careers Council of Illinois, for HCCI is the official Illinois agency for placing medical corpsmen in health jobs.)

Whether a hospital permits physicians' assistants to attend patients under the supervision of a member of its medical staff is for each to decide. This document is designed to assist in that decision and to help hospitals take the precautionary steps in creating and administering an appropriate job description.

IHA cautions that physicians' assistants must NOT be misused or abused or exploited. They must not be the excuse for a physician to practice less medicine or to practice less responsibly, nor an alternative to physician care of poor people or of people in downstate farm communities suffering from a shortage of MDs.

Definitions. "Physician's assistant" is a new term within the past two years, but it applies generically one time or another to many of the 20,000 RNs and 20,000 other people when working in Illinois hospitals under a physician's "supervision." There are nurse anesthetists, nurse aides, inhalation therapists, social workers, cast technicians, brace makers and prosthetists, medical technologists, occupational therapists, physical therapists, technicians on kidney dialysis machines and other technicians on heart pumps, etc., etc. Only a few in this list are licensed occupations. Obviously a physician's assistant may not practice a licensed vocation unless licensed in that vocation. He cannot practice medicine or professional nursing, for example.

Narrowly, the term applies to graduates -- mostly male and military corpsmen -- of a great variety of "physicians' assistants programs." Examples include the eight-week program at Johns Hopkins Hospital, three months of classroom plus 12 months preceptorship with a GP in his rural practice in the MEDEX program of the University of Washington Medical School, two years at the Duke University Medical School, and five years in the University of Colorado baccalaureate program for child health associates.

Neither of the physicians' assistants licensure-certification bills before the first 1971 session of the Illinois General Assembly was passed -- H-203 was defeated and S-24 is on postponed consideration. Neither bill contained a useful definition. The fact is that there is no accepted definition beyond the requirement that physicians' assistants work under the supervision of a physician. There are no universally accepted guidelines on the sort of work physicians' assistants can do and when it must be performed in the presence of the supervising physician. The effect is to leave it to hospitals individually to define their own meaning of the term by composing job descriptions.

Complementary definition: the supervising physician. Essential in any description of a physician's assistant is a description of the licensed physician who has qualified himself to "supervise" and "direct" assistants. There has been too little consideration of this factor. California's physician's assistant law certifies that the applicant physician is qualified to supervise, but does not certify or license the assistant himself. The application of this notion to Illinois is that any hospital medical staff member who would supervise physicians' assistants in the hospital should be required first to learn about the curricula his assistants have studied, their training and skills, and the judgmental aptitudes of each. Also, the supervising physician should satisfy himself that assistants he supervises have had sufficient training for any new tasks he will ask them to perform. This is an important principle, according to IHA legal counsel Harry L. Kinser.

A decision for hospitals individually. IHA believes that hospitals individually have the authority to decide whether physicians' assistants in the 1971 meaning of the term -- graduates of organized collegiate programs -- shall or shall not be permitted to care for the hospital's patients and to define the privileges and restrictions applicable to each assistant and to his supervising physician. IHA further believes that the decision is one to be initiated by the medical staff with the advice of administration and consent of the governing board. These decisions should be made in the light of the Darling case, namely, a hospital (its governing boards, medical staff, administration and operating staff) is legally responsible for patient care. It was no defense for the hospital that the physician who handled Darling's compound fracture was fully licensed nor that he was not an employee of the Charleston hospital.

Hospitals using physicians' assistants. These guidelines are in four steps and apply regardless of who pays the physician's assistant and whether he works fulltime or parttime in the hospital.

1. Job description

   The supervising physician(s) should draft a job description (usually with help of the hospital's personnel department) which includes:

   a. Job or functions to be performed. Be definite. "...And any other duties the supervising physician may order" is a vague function and unacceptable. There will be "sticky" questions -- Can he write "orders" and under what conditions? What technical diagnostic and therapeutic procedures

may he perform? What functions may be performed only in the physical presence of the supervising physician? How will the assistant relate with others, especially with RNs?, etc. Finally, what are the qualifications of medical staff members who shall be permitted to supervise assistants?

b. Education, training and experience required to qualify the assistant to perform the job.

2. Medical staff acceptance

The medical staff should consider the proposed job description, amend it if necessary, and formally accept or reject it as a matter of minuted record. The staff should also consider whether the new job category requires any modifications of the staff's own by-laws, rules or regulations.

3. Establishment of job description

Administration should acknowledge receipt of the job description, adopt it with appropriate wage-salary ranges in the personnel schedule of the hospital and secure the board's formal approval or at least clear with the board president. Then administration should establish the new position in the hospital's personnel process, and announce it to the hospital's operating staff through the routine procedure. It should be available for inspection by surveyors along with other personnel records.

4. Administration of the new job

The hospital's administration and medical staff must comply with the new job description.

The strongest court defense to a personal injury lawsuit arising from physicians' assistants will be the record of deliberate care in establishing the job description and evidence that the hospital and its physicians faithfully administered it.

IHA maintains a file on "physicians' assistants" working in Illinois hospitals, of their job descriptions and of whether the individuals are employed by physicians or the hospital. Please report your own hospital's practice.

David W. Stickney
Associate Director

6/9/71:bjs

xx

ILLINOIS
REGIONAL
MEDICAL
PROGRAM

*Heart Disease, Cancer, and Stroke*

*Office of the Executive Director*

*122 South Michigan Avenue · Room 939/Chicago, Illinois 60603/Telephone 312-939-7307*

July 13, 1971

TO: Regional Advisory Group
IRMP Task Forces and Committees

Physician's Assistants legislation failed to become law during this past session of the Illinois State Legislature. Nonetheless, many concerned individuals, including members of the Regional Advisory Group of the IRMP, feel that there should be a moratorium on any licensure or certification of Physician's Assistants and that the issue should not be revived when the Legislature meets in the fall.

At a recent business meeting, members of the RAG voiced support for the recommendations on Physician's Assistants made by the Ad Hoc Committee assembled by the Illinois Interagency and the Interim Organization for Chicago Area Allied Health Manpower. The Ad Hoc Committee's report, "Guidelines for Physician's Assistants Programs in Illinois," stated:

RECOMMENDATIONS
RELATED TO ISSUES OF LICENSURE AND/OR CERTIFICATION

We are opposed to any measures at this time which may require mandatory licensure or certification of Physician's Assistants by State or local authorities for the following reasons.

1. It is in the public interest to stimulate and support broadly innovative approaches to the development and utilization of new manpower. Legal restrictions at this time may seriously inhibit the process of experimentation and testing out which are necessary if we are to explore new roles, functions and patterns of manpower utilization in the health care field.

2. Major national health organizations at this time are advocating a moratorium on moves to extend licensing or

certification to new sectors of health manpower. This reflects the concern of both professional and lay groups with:

a. the excessive legalized fragmentation of the health care occupations;

b. the limitations placed by these regulations on the occupational and geographic mobility of health care workers; and

c. the general lack of public and consumer representation on licensing boards throughout the country.

3. Far more effective controls to maintain the quality of health care can be built into the institutions responsible for the training of Physician's Assistants and into those settings which utilize them as members of the health care team.

4. It is unnecessary in this State to provide statutory authority for the use of Physician's Assistants, since the Illinois Medical Practices Act already gives the physician considerable latitude in delegating tasks under his "responsible supervision."

The action taken by individuals on the RAG should not be interpreted as IRMP opposition to the Physician's Assistant concept. Quite the contrary. IRMP does not wish the development of Physician's Assistants to be inhibited by premature and restrictive licensure or certification requirements.

Individuals are urged to write to their State Legislators and express their views on this important issue.

cjs

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July 1, 1971

Mr. Don Frey
Executive Director
Health Careers Council of Illinois
410 North Michigan Avenue
Chicago, Illinois 60611

Dear Don:

In keeping with a June 17, 1971 memo from Pat Brown, Secretary, Illinois Interagency Task Force on Health Manpower, I am sending herein my comments on Guidelines for Physicians' Assistants in Illinois, to you.

First a general comment. As I look back on the development of assistant type categories of workers in other health professions, it is my impression that the professionals to be "assisted" took the leadership through their professional organizations and their education programs in planning, testing and implementing suitable educational programs and directions for practice of the graduates of those programs. This was certainly true in nursing, especially in relation to the development of practical nursing and associate degree nursing programs. Why is this not true of physicians and organized medicine in relation to "physicians' assistant" programs? I believe it is both desirable and essential.

Specific comments on the Guidelines:

1. How can a consistent set of agreed upon goals be established without some consensus from medical education or organized medicine about what they will be educated for?

2. Since it is fairly obvious that the maldistribution of physician manpower will continue, are physicians' assistants (who are not presently envisioned as professional level health workers) to relieve this maldistribution in disadvantaged inner city neighborhoods and rural areas? If not, what does the following statement (p.4) really mean: "We look to the utilization of Physicians' Assistants in these new health care institutions and settings as one way to help relieve both the manpower shortage and the maldistribution of health care personnel".

3. Illustrations of functions which it is anticipated can be performed by physicians' assistants (p.6):

   Development of the data base as described on p.6 could be done by nurses as they do a "nursing assessment" of the patient. Why introduce another worker who asks the same questions and makes the same appraisals -- perhaps not as skillfully as professional nurses could be taught to do it? Pity the poor defenseless patient!

   Health education -- and utilizing the physician's assistant as described on p.7. Are you not expecting a great deal of this technical level worker? Why not utilize other already available professional health workers, and give those professionals the necessary continuing education opportunities to enable them to make this a regular part of their professional roles? This has never been the exclusive responsibility of physicians; nor should it be. Why introduce another type of health worker for this?

   Other preventive maintenance functions:
   The examples given are already the functions of nurses; dental assistants/hygienists; and nutritionists and nurses, respectively. If physicians really worked with present other members of the health team to plan for carrying out these responsibilities, the case for physicians' assistants (with less training and scientific knowledge than other health workers mentioned) would seem to be rather flimsy.

By this time you will have concluded that I am not enthused about the physicians' assistant or the Guidelines as presently conceived, therefore I shall not comment further. To me the concept of the role, functions and preparation of this new health worker is very fuzzy indeed. Therefore I believe that all efforts to support and/or promote educational programs and recruitment into them should be tabled until there is clear direction and committment from physicians and medical educators as to what functions they are being prepared for (and why).

Sincerely,

Kay Bailey

(Mrs.) Kathryn E. Bailey
Associate Executive Director

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May 7, 1971

Mr. Don Frey, Chairman of the Ad Hoc
Committee
Illinois Interagency Task Forece
410 North Michigan Avenue
Chicago, Illinois

Dear Mr. Frey:

I regret being unable to attend the final meeting of the Ad Hoc Committee on Physicians Assistants scheduled for May 11, 1971. However, since there will be no opportunity for further discussion anyway, I assume that a written statement from me will serve your purpose just as well.

Considering the document as a whole, it appears to be substantially the same as it was prior to the last meeting and therefore, many of the same objections I raised at that time still apply. These can be summarized as follows:

1). The roles ascribed to the physicians assistant and the definitions used to describe the various levels do not appear to clearly differentiate the physicians assistant from other health workers.

2). Section VI, related to career pathways seems to represent a philosophy for change rather than specific guidelines.

3) Section VII, also seems to represent a philosophy in general, rather than a guideline for licensure of physicians assistant in particular.

In view of the above objections, I am unwilling at this time to concur in the adoption of this document as a guideline for the introduction of physicians assistant programs in Illinois.

I would like to take this opportunity to thank you for allowing me to participate in these discussions.

Sincerely,

(Mrs.) Joyce Taylor
Associate Administrator
Illinois Committee on Nursing Careers

JT:rt



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June 25, 1971

Mr. David Wandel
Administrative Assistant
Human Services Manpower Career Center
201 North Wells Street
Chicago, Illinois 60604

Dear Mr. Wandel:

I appreciate your forwarding to us copies of the "Interim Organization Chicago Area Allied Health Manpower Statement of Objectives" and the "Illinois Guidelines for Physician's Assistants," and "Barrier Removal Document."

I would be most interested in being considered as a representative or a consultant to your group. It would be most valuable in keeping me abreast as to local organization of allied health manpower and manpower utilization.

I find your organizational concept for Chicago Area Allied Health Manpower both well conceived and specific in objectives. With respect to the "Guidelines for Physician Assistant Programs in Illinois," I find this document very comprehensive and thought-out, in most instances. I feel that the definitions of types and roles of Physician Assistants, as recommended in this Illinois Guideline, is an improvement over those of the National Academy of Sciences; however, there is still some room for confusion.

I would also like to point out that the term "Physician Assistant," as trained at Duke University, is now being entitled "Physician Associate," and an organization of these persons is being incorporated under this new title. A new Journal is being marketed entitled, "The Physician's Associate." If you are interested, contact Russel F. Lawrence, Editor "Physician's Associate," P.O. Box 2914 CHS, Duke University Medical Center, Durham, North Carolina 27706.

I am particularly pleased with the recommendations relative to issues of licensure and/or certification, since the functions, roles and responsibilities for these new allied health professionals have not been completely delineated or explored for acceptance and competency at this juncture.

With respect to the "25 Barriers Document," it is limited by the fact that it did not include the 26th Barrier, which is the human propensity to resist change. I believe it is still a mark of repute as well as moral stamina in the professions to prefer obsolescence. However, I do think that the barriers, the results, and the "we need" were well stated. I would merely point out that it is not too difficult to agree on what is needed, but extremely difficult to describe and set forth what we can do - which really amounts to the action part of overcoming the barriers. The document would have more usefulness if some suggestions of action or "what can be done" was added to each of the barrier items listed.

I appreciate your sharing this useful information, and if I can be of any further assistance as a representative or a consultant, please feel free to call me.

Sincerely yours,

Wesley J. Duiker

Wesley J. Duiker, Director
Office of Allied Health Manpower

WJD:ms

PHYSICIAN'S ASSISTANT JOB DESCRIPTION AND DUTIES AS USED IN ONE ILLINOIS HOSPITAL EMPLOYING PHYSICIAN'S ASSISTANTS

PHYSICIAN'S ASSISTANT

DISTINGUISHING FEATURES OF WORK:

Under direct supervision performs responsible patient care activities necessary in the care and treatment of patients. Assists physician in whatever manner he deems necessary for the particular patient being treated at the time. May assist the physician in certain specialty areas of care such as surgery, laboratory, or other specialty areas. May take medical history of patients for the physician's review and consideration.

ILLUSTRATIVE EXAMPLES OF WORK:

1. Provides patient care activities in conformance with recognized medical techniques and procedures in accord with the established Medical Staff By-Laws and the policies of the hospital.

2. May monitor patients post-operatively and reports complications to attending physician and assists with whatever remedial measures he indicates.

3. May perform suction-decompression of the stomach with nasogastic tube, urinary catheterization, starting and regulating intravenous therapy, care and removal of drains and tubes, and any other function that is deemed necessary in the physician's judgment.

4. May record medical histories of patients and prepare them for analysis by attending physician so that he may utilize them in the diagnosis and treatment of the patient.

5. Makes rounds with physicians, both pre-operatively and post-operatively, and assists physician with any special treatments and/or dressings.

6. Collects various samples for laboratory analysis, such as blood and urine and transmits them to the laboratory.

7. Administers medication prescribed by attending physician and observes and records such information regarding a patient's condition, such as temperature, pulse, respiration, and blood pressure.

8. Reports to physician on condition of patient and initiates emergency measures to counteract unfavorable symptoms such as the administration of oxygen, glucose or other measures as directed by the physician and in conformance with hospital policies.

9. Performs other duties as required or assigned.

DESIRABLE REQUIREMENTS:

Education:

Requires knowledge, skill and mental development equivalent to completion of four years of high school, supplemented by an acceptable training program comparable to the physician assistant program sponsored by Duke University or other acceptable and educational program as determined by the medical staff and the administration of the hospital.

Significant Responsibilities:

Requires ability to observe and report patient conditions to physician. Requires ability to apply general patient care techniques and practices. Requires ability to follow and give oral and written directions in exact detail.

## INDIVIDUALS WHO PARTICIPATED IN ONE OR MORE SESSIONS OF THE AD HOC COMMITTEE

The following individuals made contributions tothis guidelines document. The listing of an individual's name does not imply that he, or the organization with which he is affiliated, is in total agreement with the contents of this document. The Committee believes its product represents a working consensus rather than unanimity. Dissenting views were also invited and are appended to this report.

Mr. Don Androzzo

Mr. George D. Benton

Dr. Patricia Brown

Mr. Peter Carruthers

Mr. Don P. Cass

Dr. Morton Creditor

Mr. Leon Dingle

Dr. Peter Farago

Mr. Joe Foley

Mr. Richard Fonte

Mr. Don Frey

Dr. John Grede

Dr. David Greeley

Dr. Charles V. Heck

Dr. Myrna B. Kassel

Dr. Stanford I. Lamberg

Dr. Israel Light

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Mrs. Frances McCann

Mr. Thomas Mitchell

Dr. Raymond Peterson

Dr. Charles Richards

Mrs. Joyce Taylor

Mr. Don VanVoorhis

Mr. David Wandel